Exhibit C

ELC CARES 2020

Emerging Issues (E) Project funding for adjusting community mitigation in response to COVID-19

CONTENTS

ELC CARES

EMERGING ISSUES (E) PROJECT

BACKGROUND

As part of the "Coronavirus Aid, Relief, and Economic Security Act" or the "CARES Act" of 2020, ELC is awarding a total of nearly $631 million to our recipient base in a program-initiated component funding under the Emerging Issues (E) Project of CK19-1904, henceforth 'ELC CARES'. The intention of this funding is to rapidly establish and monitor key activities related to COVID-19 in the areas of epidemiology, laboratory, and informatics. Monitoring the indicators associated with these activities are intended to assist State, local, and territorial governments in making data-driven policy decisions regarding testing, mitigation, and prevention efforts.

PROCESS

This funding is intended to support ELC CARES activities and associated indicator reporting for Budget Period 1 under CK19-1904; however, recipients are reminded that expanded authority applies, and activities are likely to take 24 months for completion due to the nature of COVID-19. Within 30 days of receipt of the Notice of Award (NOA), the recipient is required to submit a workplan and budget describing their ELC CARES activities.

To facilitate recipients meeting the 30-day requirement:

(1) Workplan entries will be completed in the 'ELC CARES' portal in REDCap; and
(2) Revised budgets will be completed by using the template provided via GrantSolutions Grant Notes at time of NOA issuance.
    a. Funds will be awarded under the 'Other' cost category;
    b. Recipients will adjust the cost category allocations of awarded funds to reflect the areas where financial assistance is needed; and
    c. Recipients will upload the revised budget into GrantSolutions in the form of a Grant Note, with a courtesy copy into REDCap 'ELC CARES' portal, by the 30-day post award deadline.

ACTIVITIES

1. Establish or enhance ability to aggressively identify cases, conduct contact tracing and follow up, as well as implement recommended containment measures.
    a. Enhanced contact tracing including contact elicitation/identification, contact notification, and contact follow-up. Activities could include traditional contact tracing methods as well as healthcare-specific and other proximity/location-based methods.
2. Improve morbidity and mortality surveillance, including:
    a. Establish or enhance community-based surveillance
        i. Surveillance of populations and individuals without severe illness, travel to high-risk locations, or contacts to known cases.
    b. Monitor and report daily incidence rate.
    c. Track and send Emergency Department and outpatient visits for COVID-like illness, as well as other illnesses, to CDC. Send copies of all admit, discharge, and transfer (ADT) messages to CDC National Syndromic Surveillance Program (NSSP).
    d. Monitor and utilize NHSN acute care, long-term care, and ambulatory care setting data for confirmed COVID-19 infection or for COVID-like illness.
    e. Provide accurate accounting of COVID-19 associated deaths. Establish electronic death reporting to CDC.
    f. Establish or enhance electronic case reporting from healthcare facilities to public health, including for COVID-19
3. Enhance laboratory testing and reporting capacity:
    a. Establish or expand capacity to test all symptomatic individuals, and secondarily expand capacity to achieve community-based surveillance.
    b. Screen for past infection (e.g., serology) for health care workers, employees of high-risk facilities, critical infrastructure workforce, and childcare providers.
    c. Obtain all jurisdictional laboratory test data electronically, including from new, non-traditional testing settings, and using alternative file formats (e.g., .csv or .xls) to help automate. In addition to other reportable results, this should include all COVID-19 – related testing data, including all tests to detect SAR-CoV-2 and serology testing.
    d. Report all COVID-19 – related line level testing data (negatives, positives, indeterminants, serology) daily to CDC.
4. Prevent and control COVID-19 in healthcare settings and protect other vulnerable or high-risk populations:
    a. Assess and monitor infections in healthcare workers across the healthcare spectrum.
    b. Perform preparedness assessment to ensure interventions are in place to protect high-risk populations
    c. Monitor and help implement mitigation strategies for COVID-19 in all high-risk healthcare facilities (e.g., hospitals, dialysis clinics, cancer clinics, nursing homes, and other long-term care facilities, etc.).
    d. Monitor and help implement mitigation strategies for other high-risk employment settings (e.g., meat processing facilities), and congregate living settings (e.g., prisons, youth homes, shelters).
5. Monitor and mitigate COVID-19 introductions from connected jurisdictions (i.e., neighboring cities, states; including air travel).
6. Work with healthcare system to manage and monitor system capacity.
    a. Assess and monitor the number and availability of critical care staff, necessary PPE and potentially life-saving medical equipment, as well as access to testing services.
    b. Utilize eCR data to enhance morbidity and mortality surveillance and to help monitor the health of the community and inform decisions for the delivery of public health services.
    c. Leverage NHSN data to monitor healthcare worker staffing, testing, and treatment supplies.
7. Improve understanding of jurisdictional communities with respect to COVID-19 risk:

a. Build understanding of population density and high-risk population density (i.e. population of >65 yrs., proportion of population with underlying conditions, households with limited English fluency, healthcare seeking behavior, populations without insurance and below poverty level.
b. Monitor compliance indicators (Number of Violations / complaints related to mandatory or recommended community mitigation).

See Appendix A for draft indicators to be reported to CDC; these will be finalized following the release of awards.

APPENDIX A: DRAFT INDICATORS

Public Health Capacity

Category	Indicator	Threshold
Capacity for case identification, follow up and containment	No barriers to SARS-CoV-2 testing in jurisdiction	Testing availability of 100% symptomatic individuals and exposed contacts
	Rapid identification of all newly identified COVID-19 cases by jurisdiction	Daily identification of all newly identified COVID-19 cases in the jurisdiction is achieved through active surveillance of labs and healthcare facilities.
	Rapid interviewing of new cases with full assessment of contacts	Interviews are rapidly attempted for every newly identified case, resulting in contacts being ascertained for >90% of newly identified illnesses.
	Rapid and complete follow up for identified contacts of newly identified cases	Rapid follow up (isolation, self-monitoring, and testing when indicated) initiated for >90% of identified contacts of newly identified cases.
Reduced disease burden	Consistent downward trajectory in newly identified COVID-19 cases	Consistent reductions in newly identified cases of COVID-19 over a 28-day period that represent a significant decline from peak.
	Incidence drops to a manageable level	Average daily incidence rate over the last 14 days reaches a level that does not overwhelm healthcare and public health capacity (determined locally based on resources available.)
Corroborate reductions in disease burden with other data	Reductions observed in case report data are also observed in other data	Sustained reductions also observed in one or more of the following: • ED and outpatient visits for COVID-like illness (fever, cough or shortness of breath] and absence of other cause) • Hospital admissions for confirmed COVID-19 infection or for COVID-like illness

		• Percent of SARS-CoV-2 positive tests (in the absence of major changes in how testing is being implemented locally) • COVID-19 deaths
Demonstrate control in healthcare facilities and other high-risk settings	Infections rare in healthcare personnel	Daily number of newly identified infections in healthcare personnel is near zero for 15 days and HCP infections are not causing staffing shortages.
	Decline in COVID-19 activity in high risk healthcare facilities (e.g., nursing homes, dialysis centers, long term care facilities etc.) and congregate living settings (e.g. prisons, youth homes, shelters etc.)	Sustained decline in new COVID-19 illnesses acquired in healthcare facilities and congregate living settings over the past 30 days such that potential facility outbreaks are identified rapidly and mitigated.
Assess disease burden in connected jurisdictions	The risk of introduction of a significant number of new cases from neighboring jurisdictions or air travel is low	Disease burden and trajectory in "connected jurisdictions" is not significantly different than in the home jurisdiction

APPENDIX B: INFECTION PREVENTION AND CONTROL ASSESSMENT TOOL (TELE-ICAR)

Infection Prevention and Control Assessment Tool (Tele-ICAR)

MARCH 2020 - DRAFT

[contact HAIAR@CDC.gov for updates]

Attached is an infection prevention and control assessment tool (ICAR) that can be used to help nursing homes prepare for COVID-19. This tool may also contain content relevant for assisted living facilities. The items assessed support the key strategies of: keeping COVID-19 out of the facility, identifying infections as early as possible, preventing spread of COVID-19 in the facility, assessing and optimizing personal protective equipment (PPE) supplies, and identifying and managing severe illness in residents with COVID-19. The areas assessed include:

- Visitor restriction
- Education, monitoring, and screening of healthcare personnel (HCP)
- Education, monitoring, and screening of residents
- Ensuring availability of PPE and other supplies
- Ensuring adherence to recommended infection prevention and control (IPC) practices
- Communicating with the health department and other healthcare facilities

Findings from the assessment can be used to target specific IPC preparedness activities that nursing homes can immediately focus on while continuing to keep their residents and HCP safe.

Additional Information:

- The assessment includes a combination of staff interviews and direct observation of practices in the facility and can be conducted in-person or remotely (e.g., Tele-ICAR via phone or video conferencing). Provide a copy of the tool to the facility in advance of completing the Tele-ICAR and encourage them to take their own notes as you conduct the assessment.
- Background information in the grey boxes above each section being assessed provides context for the ICAR user. This information does not need to be read during the assessment process but can be referred to for additional information.
- Assessments can be conducted by state or local health department (HD) staff, or a designee (e.g., volunteer, student), even if they do not have an extensive IPC background. The goal is to convey key messages to nursing homes and identify COVID-19 specific preparedness needs. IPC questions and concerns can be noted and addressed after the ICAR is completed.
    - Individuals completing the assessment should be given a brief introduction to COVID-19 and nursing homes as well as the use of the tool. Resources are available on the CDC website, including current guidance, a nursing home pre-recorded webinar, and additional tools
    - Engage State HD HAI/AR program leads for additional support and technical assistance is required for the facility
- Assessment activities provide an opportunity for dialogue and information sharing
    - Discuss the purpose of the assessment and emphasize that it is not a regulatory inspection and is designed to ensure the facility is prepared to quickly identify and prevent spread of COVID-19

    - Promote discussion by asking additional questions to prompt or probe. Use this opportunity to address concerns and offer available resources
- Be aware of applicable federal, state, county, or city rules, regulations (e.g., CMS requirements for nursing homes, life safety code) and governor proclamations that may impact implementation of recommended practices
- Provide feedback or a high-level summary immediately after the assessment including elements in place and areas for improvement
    - Consider scanning and providing a copy of your assessment tool or a brief summary with feedback, answers to the facility's questions, and recommended next steps directly to the facility within 2-3 days.
- Schedule a follow-up call with the facility (e.g., within the next week after the assessment findings are shared)

Investigator: Date: _____

_____

Good morning/afternoon. My name is _____ and I am calling from the _____ Department of Health. May I speak with someone who is in charge for infection prevention and control (IPC) at your facility?

Greetings, ____. My name is _____ and I am calling to discuss infection prevention and control (IPC) preparedness activities that your facility can immediately put into place to combat COVID-19 while continuing to keep your residents and healthcare personnel safe. I would like to go through an IPC assessment with you and your team if now is a good time to talk (or if possible, would you be willing to do a video call)? If not when would work best?_____

Great. As background, infection control assessment and response surveys, also referred to as ICARs (eye-cars), were developed by CDC to assist health departments in assessing IPC practices and guide quality improvement activities. ICARs are particularly useful for stopping the spread of pathogens during outbreak experiences.

Before we begin, may I get your name and contact information. Is there another person at your facility who would be the primary contact for the health department, if yes, can I get their information also??

Demographics:

Facility POC Name: _____

POC Phone: _____

POC E-mail Address: _____

- Number of beds in the facility: _____
- Total number of residents in the facility: _____
- Total number of units: _____
  - Specialty Units (check all that apply): ☐ Vent/trach ☐Dialysis ☐Dementia/Memory ☐Skilled or Subacute Rehab

    These units have residents at higher risk for poor outcomes. Vent/trach units provide respiratory support and dementia/memory units are often secured, and limit resident movement to other locations.

Which of the following situations apply to the facility? (Select all that apply)

□ No cases of COVID-19 currently reported in their community
□ Cases reported in their community
□ Sustained transmission reported in their community
□ Cases identified in their facility (either among HCP or residents)

How many days supply does the facility have of the following PPE and alcohol-based hand sanitizer (ABHS)?

Facemasks:_____
N-95 or higher-level respirators:_____
Isolation gowns:_____
Eye protection:_____
Gloves:_____
ABHS:_____

Visitor restrictions:

Both CDC and CMS recommend restricting all visitors to nursing homes to prevent COVID-19 from entering the facility. Exceptions for compassionate care, such as end of life situations, may be considered on a case-by-case basis. All visitors should first have temperature and symptom screening (e.g., cough, shortness of breath, sore throat, muscle aches) to safeguard residents. Ill visitors should not enter. Visitors who are granted access should perform frequent hand hygiene, wear a facemask, and conduct their visit in a location designated by the facility (e.g., resident's room). Additional best practices include designating a single entrance for visitors, posting signage at entrances to the facility, and providing communication to residents and families.

Elements to be assessed	Assessment (Y/N)	Notes/Areas for Improvement

• Facility restricts all visitation except for certain compassionate care situations, such as end of life situations.
• Decisions about visitation are made on a case-by-case basis.
  • Potential visitors are screened prior to entry for fever or respiratory symptoms. Those with symptoms are not permitted to enter the facility.
  • Visitors that are permitted inside, must wear a facemask while in the building and restrict their visit to the resident's room or other location designated by the facility. They are also reminded to frequently perform hand hygiene.		

• Facility has sent a communication (e.g., letter, email) to families advising them that no visitors will be allowed in the facility except for certain compassionate care situations, such as end of life, and that alternative methods for visitation (e.g., video conferencing) will be facilitated by the facility.		
• Facility has provided alternative methods for visitation (e.g., video conferencing) for residents.		
• Facility has posted signs at entrances to the facility advising that no visitors may enter the facility.		

Education, monitoring, and screening of healthcare personnel (HCP)

Education *of HCP (including consultant personnel) should explain how the IPC measures protect residents, themselves, and their loved ones, with an emphasis on hand hygiene, PPE, and* ***monitoring*** *of their symptoms. Consultant personnel are individuals who provide specialized care or services (e.g. wound care, podiatry) to residents in the facility on a periodic basis. They often work at multiple facilities in the area and should be included in education and screening efforts as they can be exposed to or serve as a source of pathogen transmission. If HCP work while ill, they can serve as a source of pathogen transmission within the facility, which is why screening is so important. HCP should be reminded not to report to work when ill. All HCP should self-monitor when they are not at work and be* ***actively screened*** *upon entering the facility. Ideally, this would occur at the entrance to the facility, before they begin their shift. Screening includes*

temperature check and asking about symptoms like subjective fever, new or worsening cough, difficulty breathing, sore throat, and muscle aches. If they have a fever of 100.0F or higher or symptoms, they should be masked and go home.		
Elements to be assessed	**Assessment (Y/N)**	**Notes/Areas for Improvement**

• Facility has provided education and refresher training to HCP (including consultant personnel) about the following:
  • COVID-19 (e.g., symptoms, how it is transmitted)
  • Sick leave policies and importance of not reporting or remaining at work when ill
  • Adherence to recommended IPC practices, including:
  o Hand hygiene
  o Selection and use of PPE; have HCP demonstrate competency with putting on and removing PPE
  o Cleaning and disinfecting environmental surfaces and resident care equipment
  • Any changes to usual policies/procedures in response to PPE or staffing shortages		

• Non-essential personnel including volunteers and non-medical service providers (e.g., salon, barbers) are restricted from entering the building.		
• All HCP are reminded to practice social distancing when in break rooms or common areas.		
• Facility screens all HCP (including ancillary staff (e.g. dietary and housekeeping) and consultant personnel) at the beginning of their shift for fever and symptoms of COVID-19 (actively records their temperature and documents absence of shortness of breath, new or change in cough, sore throat and muscle aches). • If they are ill, they are instructed to put on a facemask and return home. Ill HCP should notify their supervisor at any facility that they work at.		
• Facility keeps a list of symptomatic HCP.		
Education, monitoring, and screening of residents *Education of residents and their loved ones should include an explanation of steps the facility is taking to protect them and how visitors can serve as a source of pathogen transmission. The facility should ask residents to report if they feel feverish or have respiratory symptoms. They should actively monitor all residents upon admission and at least daily for fever and symptoms of COVID-19 (shortness of breath, new or change in cough, sore throat, muscle aches). If they have a fever (temperature of 100.0F or higher) or symptoms they should be restricted to their room and put into appropriate Transmission-Based Precautions. Group activities (e.g., communal meals, religious gatherings, classes, field trips) should be stopped to promote social distancing (residents remaining at least 6 feet apart from one another).*		
Elements to be assessed	**Assessment (Y/N)**	**Notes/Areas for Improvement**
• Facility has provided education to residents about the following: • COVID-19 (e.g., symptoms, how it is transmitted)		

• Importance of immediately informing HCP if they feel feverish or ill • Actions they can take to protect themselves (e.g., hand hygiene, covering their cough, maintaining social distancing) • Actions the facility is taking to keep them safe (e.g., visitor restrictions, changes in PPE, canceling group activities and communal dining)		
• Facility assesses residents for fever and symptoms of COVID-19 (shortness of breath, new or change in cough, sore throat, muscle aches) upon admission and at least daily throughout their stay in the facility. • Residents with suspected respiratory infection are immediately placed in appropriate Transmission-Based Precautions. • Note: Older adults with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include: new or worsening malaise, new dizziness, or diarrhea. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.		
• Facility keeps a list of symptomatic residents (link to respiratory infection surveillance tool: https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf)		
• Facility has stopped group activities inside the facility and field trips outside of the facility.		
• Facility has stopped communal dining.		
• Facility has residents who must regularly leave the facility for medically necessary purposes (e.g., residents receiving hemodialysis or chemotherapy) wear a facemask whenever they leave their room, including for procedures outside of the facility. • Consider having HCP wear all recommended PPE (gown, gloves, eye protection, N95 respirator (or facemask if not available)) for the care of these residents, regardless of presence of symptoms (if PPE supply allows). Refer to strategies for optimizing PPE supplies when shortages exist (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html).		
Additional actions when COVID-19 is identified in the facility or there is sustained transmission in the community (some facilities may choose to implement these earlier) • Residents are encouraged to remain in their room. • If there are cases in the facility, residents are restricted (to the extent possible) to their rooms except for medically necessary purposes.		

• If residents leave their room, they wear a facemask, perform hand hygiene, limit movement in the facility and perform social distancing. • Facility bundles resident care and treatment activities to minimize entries into resident room (e.g. having clinical staff clean and disinfect high-touch surfaces when in the room) • Consider implementing protocols for cohorting ill residents with dedicated HCP. • The facility monitors ill residents at least 3 times daily including symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam to identify and quickly manage serious infection		

Availability of PPE and Other Supplies

Major distributors in the United States have reported shortages of PPE. Shortages alcohol-based hand sanitizers and refills, and certain disinfectants have also been reported. Facilities should assess their current supplies of PPE and other critical materials as soon as possible and begin implementing strategies to optimize their current supply of PPE (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html). Examples of strategies described in those documents include extended use of facemasks and eye protection, which allow the same facemask and eye protection to be worn for the care of more than one resident. Gowns could be prioritized for select activities such as activities where splashes and sprays are anticipated (including aerosol generating procedures) and high-contact resident care activities that provide opportunities for transfer of pathogens to hands and clothing of HCP. If a facility anticipates or has a shortage, they should engage their health department and healthcare coalition for assistance.

- *Link to identifying your state HAI coordinator: https://www.cdc.gov/hai/state-based/index.html*
- *Link to healthcare coalition/preparedness: https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx*

Disinfectants used at a facility should be EPA-registered, hospital-grade disinfectants with an emerging viral pathogens claim against SARS-CoV-2. List N on the EPA website lists products that meet EPA's criteria for use against SARS-CoV-2 (https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2)

Elements to be assessed	**Assessment (Y/N)**	**Notes/Areas for Improvement**
• Facility has assessed current supply of PPE and other critical materials (e.g., alcohol-based hand rub, EPA-registered disinfectants, tissues). (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html)		
• If PPE shortages are identified or anticipated, facility has engaged their health department and/or healthcare coalition for assistance.		
• Facility has implemented measures to optimize current PPE supply (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html)		
• PPE is available in resident care areas (e.g., outside resident rooms). • PPE includes: gloves, gowns, facemasks, N-95 or higher-level respirators (if facility has a respiratory protection		

program and HCP are fit-tested) and eye protection (face shield or goggles).		
• EPA-registered, hospital-grade disinfectants with an emerging viral pathogens claim against SARS-CoV-2 are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.		
• Tissues and trash cans are available in common areas and resident rooms for respiratory hygiene and cough etiquette and source control.		

Infection Prevention and Control Practices

Alcohol-based hand sanitizer (ABHS) is the preferred method of hand hygiene; however, sinks should still be stocked with soap and paper towels. Hand hygiene should be performed in the following situations: before resident contact, even if PPE is worn; after contact with the resident; after contact with blood, body fluids or contaminated surfaces or equipment; before performing aseptic tasks; and after removing PPE.

Recommended PPE when caring for residents with suspected or confirmed COVID-19 includes: gloves, gown, N-95 or higher-level respirator (or facemask if respirators are not available or HCP are not fit-tested) and eye protection (face shield or goggles). PPE should be readily available outside of resident rooms, although the facility should consider assigning a staff member to shepherd supplies and encourage appropriate use.

All EPA-registered, hospital grade disinfectants have a contact time which is required to kill or inactivate pathogens. Environmental surfaces must remain wet with the product for the entire contact time duration to work appropriately. Contact times range from 30 seconds to 10 minutes. Keeping a surface wet for 10 minutes is seldom accomplished. It is important for facilities to know that their product is appropriate (List N as above) and is being used for the entire contact time. Also, it is helpful for the facility to assign responsibility for cleaning and disinfection of specific surfaces and equipment (who cleans what).

Elements to be assessed	**Assessment (Y/N)**	**Notes/Areas for Improvement**
HCP perform hand hygiene in the following situations: • Before resident contact, even if PPE is worn • After contact with the resident • After contact with blood, body fluids or contaminated surfaces or equipment • Before performing an aseptic task • After removing PPE		
HCP wear the following PPE when caring for residents with undiagnosed respiratory illness unless the suspected diagnosis required Airborne Precautions (e.g., tuberculosis): • Gloves • Isolation gown • Facemask • Eye protection (e.g., goggles or face shield) If COVID-19 is suspected, an N-95 or higher-level respirator is preferred, if available and the facility has a respiratory protection program with fit-tested HCP; facemasks are an acceptable alternative.		

• PPE are removed in a manner to prevent self-contamination, hand hygiene is performed, and new PPE are put on after each resident except as noted below.		

• Hand hygiene supplies are available in all resident care areas.
  • Alcohol-based hand sanitizer* with 60-95% alcohol is available in every resident room and other resident care and common areas.
  • Sinks are stocked with soap and paper towels.
• *If there are shortages of ABHS, hand hygiene using soap and water is still expected.		

• Hand hygiene and PPE compliance are audited		
• Non-dedicated, non-disposable resident care equipment is cleaned and disinfected after each use.		
• EPA-registered, hospital-grade disinfectants with an emerging viral pathogens claim* against SARS-CoV-2 are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment. • *See EPA List N: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2 • Name of EPA-registered disinfectant used in facility: • Contact time for EPA-registered disinfectant:		
• EPA-registered disinfectants are prepared and used in accordance with label instructions.		
• Facility is aware of the contact time for the EPA-registered disinfectant and shares this information with HCP		
Additional actions when COVID-19 is identified in the community (some facilities may choose to implement these earlier) • Facility has implemented universal use of facemasks for HCP (for source control) while in the facility. If facemasks are in short supply, they are prioritized for direct care personnel. • All HCP are reminded to practice social distancing when in break rooms or common areas.		
Additional actions when COVID-19 is identified in the facility or there is sustained transmission in the community (some facilities may choose to implement these earlier) • Consider having HCP wear all recommended PPE (gown, gloves, eye protection, N95 respirator or, if not available, a facemask) for the care of all residents, regardless of presence of symptoms. This is done (if PPE supply allows) when COVID-19 is identified in the facility. Refer to strategies for optimizing PPE when shortages exist. This approach is recommended to account for residents who are infected but not manifesting symptoms. Recent experience suggests that a substantial proportion of long-term care residents with COVID-19 do not demonstrate symptoms.		
Communication		

Communicating is essential during an outbreak, with HCP, residents, families, the health department, transport personnel and receiving facilities. Facilities should notify the health department about any resident with severe respiratory infection, identification of residents or HCP with suspected or confirmed COVID-19, or if the facility identifies more than 2 cases of respiratory illness among residents and/or HCP in 72 hours. These situations should prompt further investigation and testing for SARS-CoV-2. Should a higher level of care be indicated for a resident with suspected or confirmed COVID-19, the facility should communicate this information with transport personnel, the receiving facility, and the health department.		
Elements to be assessed	**Assessment (Y/N)**	**Notes/Areas for Improvement**
Facility notifies the health department about any of the following: • COVID-19 is suspected or confirmed in a resident or healthcare provider • A resident has severe respiratory infection • A cluster of new-onset respiratory symptoms among residents or HCP (e.g., ≥3 cases over 72 hours)		
• Facility has process to notify residents, families and staff members about COVID-19 cases occurring in the facility.		
• Facility communicates information about known or suspected COVID-19 residents to appropriate personnel (e.g., transport personnel, receiving facility) before transferring them to healthcare facilities (e.g. dialysis and acute care facilities).		